DELINEATION OF CLINICAL PRIVILEGES - UROLOGY

(For use of this form, see AR 40-68; the proponent agency is OTSG.)

1. NAME OF PROVIDER *(Last, First, MI)*	2. RANK/GRADE	3. FACILITY

INSTRUCTIONS:

PROVIDER: Enter the appropriate provider code in the column marked "REQUESTED". Each category and/or individual privilege listed must be coded. For procedures listed, line through and initial any criteria/applications that do not apply. Your signature is required at the end of Section I. Once approved, any revisions or corrections to this list of privileges will require you to submit a new DA Form 5440.

SUPERVISOR: Review each category and/or individual privilege coded by the provider and enter the appropriate approval code in the column marked "APPROVED". This serves as your recommendation to the commander who is the approval authority. Your overall recommendation and signature are required in Section II of this form.

NOTE: This form is to be used as an attachment to DA Form 5440-13 (Delineation of Clinical Privileges - General Surgery).

PROVIDER CODES	APPROVAL CODES
1 - Fully competent to perform	1 - Approved as fully competent
2 - Modification requested *(Justification attached)*	2 - Modification required *(Justification noted)*
3 - Supervision requested	3 - Supervision required
4 - Not requested due to lack of expertise	4 - Not approved, insufficient expertise
5 - Not requested due to lack of facility support	5 - Not approved, insufficient facility support

UROLOGICAL CANCER SURGERY

Requested	Approved		Requested	Approved	
		a. Radical/Partial Nephrectomy			f. Ileal Conduit
		b. Radical Cystectomy			g. Continent Diversion
		c. Radical/Simple Prostatectomy			h. Ultrasound-guided Prostate Biopsy
		d. Radical Orchiectomy			
		e. Exenterative Procedures			

INFERTILITY SURGERY

Requested	Approved		Requested	Approved	
		a. Vasectomy			d. Varicocelectomy
		b. Vasovasectomy			
		c. Vasoepididymostomy *(microscopic approach)*			

LAPAROSCOPIC SURGERY

Requested	Approved		Requested	Approved	
		a. Pelvic Lymphadenectomy			d. Diagnostic Laparoscopy
		b. Varicocelectomy			
		c. Nephrectomy			

STONE SURGERY

Requested	Approved		Requested	Approved	
		a. Uretero-Pyeloscopy			c. Extracorporeal Shock Wave Lithotripsy
		b. Open Lithotomy			

ENDOSCOPIC SURGERY

Requested	Approved		Requested	Approved	
		a. Transuretheral Resection of the Prostate			d. Cystoscopy
		b. Transuretheral Resection of the Bladder			e. Percutaneous Endoscopic Surgery
		c. Endoscopic Surgery of the Urethra			

SURGERY FOR IMPOTENCE

Requested	Approved		Requested	Approved	
		a. Placement of Penile Prosthesis			
		b. Penile Orthoplasty			

FEMALE UROLOGY

Requested	Approved		Requested	Approved	
		a. Bladder Neck Suspension			c. Major Reconstruction
		b. Bladder Sling			

PEDIATRIC UROLOGY					
Requested	Approved		Requested	Approved	
		a. Hypospadias Repair			d. Surgery for Congenital Anomalies
		b. Orchiopexy			
		c. Reconstructive Procedures of Genitalia, Bladder, Ureter, Kidney			

RECONSTRUCTIVE SURGERY					
Requested	Approved		Requested	Approved	
		a. Placement of Artificial Urinary Sphincter			d. Pyeloplasty
		b. Male Sling Surgery			
		c. Open Urethroplasty			

COMMENTS

	SIGNATURE OF PROVIDER	DATE *(YYYYMMDD)*

SECTION II - SUPERVISOR'S RECOMMENDATION

Approval as requested ☐ Approval with Modifications *(Specify below)* ☐ Disapproval *(Specify below)* ☐

COMMENTS

DEPARTMENT/SERVICE CHIEF *(Typed name and title)*	SIGNATURE	DATE *(YYYYMMDD)*

SECTION III - CREDENTIALS COMMITTEE RECOMMENDATION

Approval as requested ☐ Approval with Modifications *(Specify below)* ☐ Disapproval *(Specify below)* ☐

COMMENTS

CREDENTIALS COMMITTEE CHAIRPERSON *(Name and rank)*	SIGNATURE	DATE *(YYYYMMDD)*

EVALUATION OF CLINICAL PRIVILEGES - UROLOGY

(For use of this form, see AR 40-68; the proponent agency is OTSG.)

1. NAME OF PROVIDER *(Last, First, MI)*	2. RANK/GRADE	3. PERIOD OF EVALUATION *(YYYYMMDD)* FROM TO
4. DEPARTMENT/SERVICE	5. FACILITY *(Name and Address: City/State/ZIP Code)*	

INSTRUCTIONS: Evaluation of clinical privileges is based on the provider's demonstrated patient management abilities appropriate to this discipline, and his/her competence to perform the various technical skills and procedures indicated below. All privileges applicable to this provider will be evaluated. For procedures listed, line through and initial any criteria/applications that do not apply. The privilege approval code (see corresponding DA Form 5440) will be entered in the left column titled "CODE" for each category or individual privilege. Those with an approval code of "4" or "5" will be marked "Not Applicable". Any rating that is "Unacceptable" must be explained in SECTION II - "COMMENTS". Comments on this evaluation must be taken into consideration as part of the provider's reappraisal/renewal of clinical privileges and appointment/reappointment to the medical staff.

SECTION I - DEPARTMENT/SERVICE CHIEF EVALUATION

CODE	PROCEDURE/SKILL	ACCEPTABLE	UN-ACCEPTABLE	NOT APPLICABLE
	UROLOGICAL CANCER SURGERY			
	a. Radical/Partial Nephrectomy			
	b. Radical Cystectomy			
	c. Radical/Simple Prostatectomy			
	d. Radical Orchiectomy			
	e. Exenterative Procedures			
	f. Ileal Conduit			
	g. Continent Diversion			
	h. Ultrasound-guided Prostate Biopsy			
	INFERTILITY SURGERY			
	a. Vasectomy			
	b. Vasovasectomy			
	c. Vasoepididymostomy *(microscopic approach)*			
	d. Varicocelectomy			
	LAPAROSCOPIC SURGERY			
	a. Pelvic Lymphadenectomy			
	b. Varicocelectomy			
	c. Nephrectomy			
	d. Diagnostic Laparoscopy			
	STONE SURGERY			
	a. Uretero-Pyeloscopy			
	b. Open Lithotomy			
	c. Extracorporeal Shock Wave Lithotripsy			
	ENDOSCOPIC SURGERY			
	a. Transuretheral Resection of the Prostate			
	b. Transuretheral Resection of the Bladder			
	c. Endoscopic Surgery of the Urethra			
	d. Cystoscopy			
	e. Percutaneous Endoscopic Surgery			

CODE	SURGERY FOR IMPOTENCE	ACCEPTABLE	UN-ACCEPTABLE	NOT APPLICABLE
	a. Placement of Penile Prosthesis			
	b. Penile Orthoplasty			
	FEMALE UROLOGY			
	a. Bladder Neck Suspension			
	b. Bladder Sling			
	c. Major Reconstruction			
	PEDIATRIC UROLOGY			
	a. Hypospadias Repair			
	b. Orchiopexy			
	c. Reconstructive Procedures of Genitalia, Bladder, Ureter, Kidney			
	d. Surgery for Congenital Anomalies			
	RECONSTRUCTIVE SURGERY			
	a. Placement of Artificial Urinary Sphincter			
	b. Male Sling Surgery			
	c. Open Urethroplasty			
	d. Pyeloplasty			

SECTION II - COMMENTS *(Explain any rating that is "Unacceptable".)*

NAME AND TITLE OF EVALUATOR	SIGNATURE	DATE *(YYYYMMDD)*